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PROBLEMS IN THE APPROACH TO THE NEUROSES AND PSYCHOSES IN GENERAL PRACTICE*

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RECENTLY a surgeon and a psychiatrist gave a joint clinical presentation for fourth year medical students and house officers. As their patient they discussed a woman in her late forty's, who had been an invalid for many years after nine abdominal operations in several hospitals and after going through every conceivable laboratory investigation, some of them several times. Her symptoms still persisted unremittingly, and although there were no demonstrable organic lesions she was on a steadily downhill course.

The story went back to her eleventh year, when she had first been brought to a hospital with a pain in her stomach. An intelligent young physician had said, "This child is nervously upset. She needs psychiatric study and maybe treatment." Then he had sent her home with some aspirin. Unfortunately the aspirin worked wonders, and she remained symptom-free for two years. Then she appeared at another hospital with the same symptoms. This time her appendix was removed,

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and subsequently she was reoperated for "adhesions." This started her on her course through all the other operations and examinations; and it was not until nearly thirty-five years later that the first young surgeon's suggestion that the patient have psychiatric help was heeded. At long last she was brought for a psychiatric consultation; but by then psychiatry could no longer help her, since no psychiatrist could turn back the hands of time to her eleventh year.

My colleagues and I did a little calculating; and by gathering together all of the facts and making conservative estimates as to the number of laboratory technicians, nurses, physicians of various rank, and other staff who had been involved in her care and the amount of time each had given, we figured that as a minimal estimate this patient had received at least 5,600 free hours of attention from American medicine, only to become a helpless and hopeless invalid for life as a direct result of this fantastic generosity. This made us wonder what her life might have been had she received 50 hours of preventive psychiatric help when she was eleven years old; and if someone had taken the trouble to visit her home so as to back up in that home the psychiatric help which she could have received in the clinic. Fifty hours of psychiatric prevention against 5,600 hours of surgery and medicine, which had been not only wasted but actually destructive.

This is not an extreme or exceptional example. Indeed such cases constitute the greatest single reason for the shortage of medical facilities in this most lavishly supplied of all countries. Some years ago I made a study of the repeat admissions of patients to a large general hospital. A random sampling of these patients and of their hospital records proved that a failure to give early psychiatric treatment and failure to do psychiatric screening on admission accounted for a large part of the hospital's repeaters. This is a load which uses up a fantastically large proportion of hospital beds, plus the time of physicians, nurses, technicians and secretaries, plus drugs and technical supplies. The economy that could be effected by adequate early use of psychiatry both for the detection of psychiatric ailments and for their early therapy is almost incalculable. It would be an economy for every general hospital, for all hospital personnel, for individual private practitioners, but above all in the lives of our patients. This is one of the many social values of the preventive use of psychiatry.

The preventive use of psychiatry is of importance from

still another point of view. The staggering burden of patients in our public and private mental hospitals is well-known to everyone. We know that there are more beds in mental hospitals than in all other hospital facilities in the country. Furthermore, we know that with increasing longevity the number of senile and pre-senile patients is increasing, and will continue to increase until the metabolic and vascular problems of old age are solved. What is not so well known, however, is the fact that there are many patients in mental hospitals whose illnesses are not due to organic changes in the brain but represent rather the end-states of untreated or inadequately treated neuroses. As to this it is important to be clear about what I am *not* saying. I am not saying that *every* untreated or inadequately treated neurosis ends up as a psychosis. Fortunately this is not true. Many untreated or inadequately treated neuroses stabilize on a plateau, which is half-way between health and a complete mental breakdown, without reaching either a spontaneous cure or a spontaneous decompensation. On the other hand I have never seen a psychosis which failed to give a history of an untreated or inadequately treated pre-existing neurosis, out of which the psychosis had grown. Again I am not claiming that the early treatment of every neurosis can prevent the development of a later psychosis. One can say only that adequate treatment in childhood, adolescence, and early adult years can prevent the development of a very large number of later psychotic breakdowns, but not of all.

Clearly then in the daily practice of organic medicine in general hospitals, in out-patient clinics, and in the private office, it is of prime importance to recognize and to treat as early as possible the universal neurotic component in all patients, no matter what their organic ailments, so as to lessen the burden of the mentally ill in hospital, to spare the suffering of human beings who battle throughout their lives with uncured neuroses, and to lessen the fantastic waste of medical and surgical manpower, facilities, and supplies.

Any effort to implement such a program creates many new problems for the physician; and it is to these that I want to devote some thought. First let us face the fact that it is one thing to recognize in someone else the need for treatment: it is quite another to recognize it in oneself or in a member of one's family. Every physician soon realizes this when he sets out to convince someone that he himself or some relative should consult a psychiatrist. Only rarely are we willing to

accept such a recommendation at once. Sometimes the patient is willing, and the family objects. Sometimes the family is eager and the patient objects. Sometimes trusted medical and surgical advisors constitute his psychiatric majesty's loyal opposition. In general where the patient's symptoms make his family uncomfortable, the family urges treatment while the patient objects: whereas where the symptoms make the patient uncomfortable, he seeks help, while the family tends to regard this as much ado about nothing. For instance, if a patient has a counting compulsion of such severity that he has to count every book in a room before he can enter it or leave it, he will come for help without much urging. Or the patient who suffers from extremely painful anxieties, or who has a fear of traffic or of open places so great that he cannot leave his home, or who has fear of dirt which makes him wash his hands until the skin peels away: all of these seek help of their own accord. No one needs to diagnose them or to persuade them. They come begging the psychiatrist to give them help. These, however, are all fully developed neuroses. The issue here is not one of early preventive treatment, but of belated treatment in an effort to reclaim someone who is already deeply enmeshed in illness. But in the larval stages of a neurosis a patient's symptoms not infrequently are more uncomfortable for the family than for the patient; and it will be the family who urges treatment, while the patient remains relatively complacent. In these ways difficult problems arise whenever we attempt to use psychiatry preventively with patients whose illnesses are still in larval form: and it is precisely here that the general physician or surgeon finds himself up against problems which are different from those which confront him when he makes any other kind of referral.

He will find that patients do not want to be told that they are in danger of developing serious psychological disturbances and that they require preventive psychiatric treatment. Furthermore, families may be as reluctant as patients to hear such advice; because such warnings frighten everyone, by arousing a primitive terror of going insane. This fear in turn often turns into anger, with the result that the patient may run from the physician or surgeon who has made this sound recommendation to some less astute medical advisor who will be more reassuring. Some patients change from one doctor to another many times because each physician in turn urges psychiatric treatment, ultimately accepting psychiatry only many years after such a referral was first

attempted. During the years which are lost in this way the neurosis itself becomes more complex, irradiating into more aspects of life, thereby becoming ever more difficult to treat. A disturbance which could have been disposed of in a few months, had a patient sought help for his difficulty when it was first suggested, may become almost untreatable at the end of a dozen years of stalling.

Furthermore, in addition to a patient's own fear of insanity, we often must overcome the same terror in the patient's family. I have recently been consulted by a woman who needs and wants help very much. Unfortunately her husband, a brilliant and creative scientist, is even sicker than she is: but it is part of his illness that he is terrified at the mere thought of psychiatry, whether for his wife or for himself. For her to receive treatment would bring the whole subject too close to his doorstep for comfort. Any mention of it throws him into a state of terror and rage. Furthermore, jealousy of men plays so important a role in his reactions that I have urged that if his wife is to be treated at all it should be by a woman.

The fear of psychological disturbances is deeper in our culture than is ordinarily realized. It arises out of many complicated confusions of our early years: and it is linked to many superstitions. It can lie dormant for long years only to explode on slight provocation. When a patient finally comes for treatment, many of the buried fears which lay behind his prolonged flight from psychiatry may come to light for the first time. For instance one may find that he felt that to face illness and think about it would actually bring it on; or he may have felt that a public acknowledgment of psychological difficulties constituted a public acknowledgment of private shame.

Thus in addition to these secret but nearly universal terrors of insanity, which may be touched off at the mere thought of a psychiatric consultation, we must also deal with and overcome the quite special sense of shame, which surrounds any acknowledgment of a need for psychological help. To many people this is tantamount to a public confession of moral or spiritual inferiority. Certainly the tendency to play ostrich is not peculiar to the responses of human beings to psychiatry. In most of us there is a carry-over from childhood of the feeling that if we do not think about something, and if we do not talk about it, it won't happen. Yet a special type of conscious and unconscious mythology can be discovered in the universal

sense of shame about mental troubles. This is the feeling that for anything to go wrong in mental functions indicates either an inherent inferiority, or else that we have done something shameful to ourselves. We are guilty in some mysterious and humiliating way: and the acknowledgment of the illness is tantamount to a public humiliation. When medicine attempts to deal preventively with cancer or tuberculosis, it runs into a part of this problem. Thus there are people who would prefer not to go to a doctor for a periodic physical check-up as though the periodic examination in itself would invite not the detection of the early stages of some illness but the illness itself. In psychiatry we are opposed not merely by this feeling that to face reality is to court disaster: but also by this sense of public shame. Perhaps it is precisely because such illness is psychological that this feeling has such a special intensity. However that may be, all of these attitudes conspire to block our efforts to induce patients to accept their need for treatment early enough so that we can use treatment for preventive purposes.

In maneuvering our way around these obstacles it is always helpful for the internist, surgeon, and psychiatrist, to plan their campaign jointly. This means time-consuming conferences, most of which are unremunerated, many of which are wasted, but which can also be enormously rewarding. Let me describe examples both of success and of failures, because we can learn only by contrasting them. This will take us to the autopsy table of experience, to stories which have unhappy as well as stories which have happy endings. Perhaps it will leave a better taste in your mouth, if we begin with a happy tale.

Many years ago one of my colleagues phoned to me and said: "You are a neurologist, aren't you?" Somewhat mystified I said, "Yes." He then said, "You would *not* be a psychiatrist, would you?" I began to catch on, and said, "Good Lord, no." He said, "Well, I am glad to hear that, because Mr. and Mrs. X are sitting here with me. Their daughter has been in bed for nearly a year; and I think that she needs a careful neurological examination and perhaps treatment by you. Mrs. X says that if it is absolutely necessary she will allow her child to see a neurologist, but under no circumstances must she ever see a psychiatrist." That was how we began; and it took long and careful work, an intellectual and spiritual wooing of these parents, to win them from their deep terror of and bias against psychiatry, before this youngster could receive the analytical treatment which she needed. The end was

a happy and successful life: complete health, success in college, a career, a happy marriage and a family of youngsters. Not long ago that same mother, now quite old, came to visit me and referred to this original telephone call fifteen years ago. She told me shyly that in her will she was leaving money to pay for the analytic treatment of some impecunious youngster, the age that her daughter had been when this "neurologist" was first called in.

How often, I wonder, do consultants in internal medicine or in surgery or in other organic specialties have to deny their own special fields, as a necessary prelude to bringing help to a patient?

Now let me describe a typical failure. Four years ago three colleagues and I sat together with the family of a patient who had been in and out of hospitals for quite a number of years. Two important therapeutic weapons had not been tried; because the family had never been able to commit itself wholeheartedly to any sustained program of treatment. The story of this patient's descent into chronic illness was not a story of the inevitable downward progress of an unalterable pathological process. It was rather the story of familial vacillations, of the fluctuating opposition of the parents, of the husband, and of two other medical advisors. Whenever the patient slumped they cried for help. Whenever the patient improved they pretended that it had all been a false alarm. Again each of those who made up the emotional climate of this patient's life was himself a sick human being. Yet not one of them was ready to face his own illness or his own need for treatment. As a consequence every time any program of therapy was begun with this unfortunate patient, before it had been underway very long, one or another of these relations would interrupt it. On one occasion the patient was actually kidnapped from a hospital while on an afternoon's outing with a relative. The tragedy of this was that the patient could have been cured: but in order to gain access to him we would have had to cure the neuroses of at least four individuals who opposed the patient's treatment, simply because not one of the four would face the fact that it was his own neurosis that he was protecting. This patient's life ended in a wholly unnecessary suicide. Again, where else in medicine does one encounter this kind of obstacle merely to bringing treatment to an ailing human being. Here again we are confronted by that same old superstition: "If you face and admit it, you bring it on," like the child with a nightmare who hopes that if he does not open his eyes and does not

look, the dreadful thing will no longer be there. This is the attitude that most people bring to psychiatric problems, i.e., biases and prejudices which arise out of deep human shames and terrors.

In the approach to treatment another problem arises which puts heavy and exceptional demands on the referring physician. He has to allow patients enough time to adjust themselves to the plans for psychotherapy which he is trying to work out. He must allow the feeling of illness to develop parallel to the growth of a confidence that help is available. If the sense of illness and the attending alarm develop too rapidly, the patient is likely to run away, dismissing all warnings, calling the physician an alarmist, and a Cassandra. If, on the other hand, the physician is over-optimistic about the availability of help, then the patient may expect instant miracles and immediate relief.

And all this time the patient and the patient's family tend to hear only what they want to hear. We all learn to accept with what equanimity we can muster the distorted echoes of our own words, so altered that we blush to think that this is what will be reported to others as being our words of so-called "wisdom." That is daily diet for the psychiatrist who frequently can barely recognize his own words when he hears their echo. It is an experience to which the general practitioner also becomes accustomed as soon as he invades this field: and he will hear his advice misquoted and reduced to absurdities many times before it is accepted.

One of the natural mistakes which the referring physician frequently makes, and which can cause serious trouble later on, is to convince a patient ahead of time that there is some form of therapy or some one psychiatrist who holds the key to health, without regard to the question of whether or not that particular therapy is appropriate for the illness in question; and equally without regard to the question of whether that "one" psychiatrist will have an opening on his schedule. The psychiatric treatment of each individual patient makes such heavy demands on the psychiatrist's time that he cannot conscientiously undertake the treatment of more than a limited number of individuals. There have been times when I was already working 14 hours a day, only to have a friendly colleague call me up to say to me, "You must take on John Jones. I have worked for years to get him to come to see you. He won't go to anybody else. Now he is ready: and we must strike while the iron is hot. If you say no, I do not know what is going to happen to him." He had sold John Jones not on his need for psychiatry, but on

a fantasy that I was the only sound man in an unsound field, indeed *the only* miracle worker. My colleague had done John Jones no service. Consequently every psychiatrist has had the experience of having patients come, persuaded that they could be cured by only one specific method, e.g., by hypnotism, by some brief form of psychotherapy, by analysis alone, etc., when the case may actually be incurable, or it may be one that cannot possibly be treated by hypnosis without great risk, or for whom analysis is wholly inapplicable, or where the thought of brief psychotherapy is preposterous. Certainly to seduce a patient into treatment by holding out false hopes, or to impose on a patient one's own convictions as to the form of therapy which may ultimately prove desirable is quite as undesirable in psychiatry as it is in any other field of medicine.

I point out such errors as these not in order to criticize our colleagues, but because they are natural errors into which we are led in our sometimes desperate efforts to deal with the intrenched opposition to the early use of psychiatry which I have been describing. We are driven by our growing realization of the enormous importance of tackling these problems before they become chronic and before they have distorted human life. Yet in the families of our patients as in our patients themselves we are opposed by these many forces which lead to postponements of the evil day. It is natural for the physician to try to bypass this opposition by holding up a hope of quick and easy therapeutic results, or by stressing the miraculous value of some new technical development in psychotherapy or the special virtues of some one individual, or by promising to keep a constant eye on the progress of the treatment, and the like. I have full sympathy with this. Indeed, I have made everyone of these mistakes myself in attempts to induce reluctant patients to go into treatment with fellow psychiatrists. Frequently in dealing with reluctant patients I rule myself out as the therapist, so that at least they will not feel that I am merely cooking up trade for myself. Thus I make myself a relatively disinterested advisor. By this device, except for being a psychiatrist and having an axe to grind for psychiatry, I am in the same position as any other referring physician. Therefore, I know how strong the temptation is to use any argument to persuade a reluctant patient and his reluctant family not to lose valuable time: and I have learned of these errors which I am criticizing by committing them all. Therefore, I cannot urge too strongly that they be avoided. As one

of the ablest of my colleagues said to me the other day, "I feel happiest about my ability to help a patient when the patient comes to me and persuades me that he needs and wants and deserves and should have treatment." The popular idea that intensive psychotherapy is an emotional bubble-bath is far from the truth, as I am sure you all realize. It is as tough an experience as a human being can undergo. And unless the patient comes with his own urgent and insistent demand for help, he is not likely to get much out of his treatment. One index of its probable value will be the urgency of the demand that comes from the patient himself, rather than from the patient's advisors. To this rule, as to all rules, there is, however, at least one important exception. Some patients come reluctantly, grudgingly, and only after heavy pressure has been used. Once they are over the hurdle they generate an intense and earnest purpose of their own. This happens especially if the anticipatory reluctance is due largely to a kind of stage-fright. It is hard to predict when this will happen: but the possibility must be kept in mind and justifies us in doing our best to induce reluctant patients to make a tentative trial of treatment.

In my own experience there is no perfect way of dealing with the deep-rooted fears, biases, and prejudices, and mythological shames, which have to be overcome in bringing patients to treatment. One must represent reality, however, by gently bringing these fears and shames into the open. The patients themselves and their families will never speak of them spontaneously. The physician must do the talking for them, discussing quite freely the inarticulate attitudes which our culture engenders in us, or which seem sometimes to arise almost spontaneously. A certain number of people will respond at once to such frankness with an eager sense of release. For them open discussion can tilt the balance in the direction of accepting the aid that one is holding out to them. In others, in whom there are deeper, more personal neurotic roots to their opposition, frankness will make their reluctance less articulate, more solid, and more rigid. When up against this, one simply has to accept the fact and wait unhappily until the neurosis itself takes such a toll of life and causes so much pain that the patients can no longer turn away from treatment. Do not think that this is easy. It is a frequent breeder of tragedy. Because not infrequently it means waiting until a psychotic decompensation has broken down the opposition to treatment which the family physician was unable to overcome.

I think back to one of the most tragic experiences of my entire life as a psychiatrist. One of the finest women who ever consulted me came almost demanding to be analyzed. I was perplexed by her urgency even though she brought a recommendation from a colleague in another city that she should indeed be analyzed. We began work; but within a few weeks it became clear that the wrong person was on the couch. This woman did not need analysis, although she did need help and advice desperately. She was married to a man who suffered from a bitter, hostile, paranoid, and destructive neurosis; a neurosis which was threatening to destroy their only child and certain other people besides. Yet he would not face his illness or his need for help. This woman had come in a desperate effort to heal *him* by absent treatment, with the fantasy that by some superhuman adjustment she would be able to ease the pressure of his neurosis. I was in the unfortunate position of having to tell her that *she* did not need that kind of treatment, that I would help and advise in any way that I could, but that I literally feared for her safety. I also worked with her for weeks on methods by which he might be induced to seek treatment: but never to any avail. It was only then that I made her face the possibility that she might be risking her own life and her child's. This was too much for her to accept; and she left, ultimately paying for her reluctance to face reality with her death; because he killed her and himself and nearly succeeded in killing their child. I stress this because it is important to accept humbly the fact that we are not omniscient or omnipotent and that this is an area of medicine in which we often meet defeat, and that our best efforts to induce patients to accept preventive treatment often meets this fate.

This is of particular importance when we deal with a neurosis which is masked by an organic disease. We all know that we can have measles and a broken leg. What is not always recognized is how frequently an organic disease masks a neurosis. For every patient who gets emotionally upset when he falls ill, there are a hundred who sit back with comfortable complacency and a great sigh of relief feeling, "Isn't this wonderful? Here I am sick. I am laid up in bed. I will be taken care of. I don't have to go to work. I am free of my responsibilities." Sometimes it is just a stressful, external situation from which the patient takes a temporary vacation. Sometimes it is a subtle and deeply buried internal problem from which the organic illness offers an escape. Such

individuals make ideal patients while sick; and the emotional storm begins only when they are convalescent or when they face leaving the hospital to go home. Obviously then if we want to use psychiatry preventively in daily practice or on the medical or surgical wards of a hospital, we must offer psychiatry not only to patients who are obviously disturbed but also to patients with unrecognized emotional problems of which they are not aware. Indeed this will ultimately be our greatest opportunity. I saw in consultation a few weeks ago a fine young mother whose only complaint was an unexplained fever and fatigue. An astute family physician recognized that whatever might be the physiological mechanism of this minor disturbance in temperature regulation, it was somehow tied up to an insidious but important emotional problem. The background was revealing. She had been brought up in a patriarchal atmosphere quite rare in this matriarchal culture of ours. Her grandfather, father, and brothers had completely dominated the home picture. She was the only girl child in the family; and of necessity, although she was the little princess, she was trained to be a meek one. Underneath was a rebellious and tough little spirit. Ultimately she married a firm, strong ally, i.e., an extremely vigorous man who, as could have been predicted, turned out to be just as patriarchal as her father and her grandfather had been. Then she became the mother of sons who grew up to be vigorous, healthy boys of whom she was enormously proud. But she began to feel herself hemmed in again, caught up in a fantastic reliving of the pressures of her earliest years. Anyone with eyes in his head could see that this young woman was heading for difficulties in which she would need help. Yet she had always led a vigorous and healthy life. How to bring her to use psychiatry preventively was the problem that confronted her far-sighted internist, and a problem that confronted me. This was complicated by the fact that to accept her need for treatment was like accepting an inferior status, a stamp of inferiority. Treatment itself was to her a confirmation of the very stigma that she had spent her life fighting against. How did we deal with it? In the first place by pointing out the chain of events and circumstances which were slowly steering her into difficulty. In the second place by indicating how much more difficult these problems were bound to become before they got easier. Third, by trying to make her see that as inevitably as the progress of the seasons or the law of gravity, they

were generating in her certain stormy reactions; and that to face these was no indication of weakness or of inadequacy or inferiority. Will she accept this? We do not yet know. The matter has been sub judice now for three years. Every once in a while when she becomes especially fatigued and the temperature balance goes off, the issue comes up. Then it disappears again, when for the time being the problems recede and the pressures become less. My hope is that she will ultimately accept treatment. She may be 40 by that time; and we may then wish that she had accepted it at 30. But I know of no way, in a situation of this kind where the neurotic forces are well compensated, by which we can force the issue in any precipitate form. There is no one who can prophesy dire disaster. And there is no way of proving that our prophesy would come true. We can say only that the chances are that she will lead a fuller, freer, happier, more deeply rewarding life if she rids herself of some of the scars which the special circumstances of her early life have left in her, and which now are vulnerable to the special circumstances of her adult years. Holding that simple, inescapable fact up to her from time to time is slowly beginning to whittle away at her defenses, and is opening her thoughts to the possibility of life's enrichment. This is at least as persuasive as any dire predictions of later unhappiness. In such a case what do I mean by later unhappiness? I mean quite specifically the prevention of the so-called involutional melancholias of the 40's and the 50's, which evolve with such fateful inevitability out of just such masked neuroses of the 20's and the 30's.

This leads us, however, to another one of the anomalies of the psychiatrist's position. When he does persuade a patient to accept psychiatric treatment preventively, he has no way of proving that his prophesies of doom would have come true had they been neglected. He cannot split his patient down the middle and treat one half and keep the other half for control. How often I have wished that I could. We can only depend on our own best judgments and that of our colleagues, and our opportunities to compare the outcome of comparable neuroses in different individuals, when they are treated in late adolescence or early adult years with the outcome when they remain untreated.

This point will be illustrated further by another of the anomalies of daily practice, the fate of the so-called "campus hero." This is a

diagnosis that I make with increasing frequency: the "campus hero." I wish that our universities would pay more attention to this problem. The campus hero is a man or woman who comes to me in his 30's or 40's, or 50's with a severe neurosis or perhaps on the edge of a psychosis, with a life story of uninterrupted success and leadership in childhood, school, adolescence, and early adult years; in sports, studies, and in social life. He or she had been regarded as the model of the well-adjusted young individual. Why then did he fall ill? One goes back and examines with greater detail what was going on below the surface and finds that this smooth adjustment had been a cover for many stormy problems, problems which this individual had been able to master and hold in check and hide, but never to get rid of. One wishes that his life had not been so smooth, and that his problems had tripped him up at some point, forcing him to pay more attention to them, forcing earlier treatment. Such experiences have made me suspicious of too smooth a course through those early years: because if we know anything about human development, it is that we do not yet know how to bring up emotionally healthy human beings. Therefore the apparently smoothly adjusted youth and adolescent and young adult is usually a simulacrum of health, and not the genuine article. This I believe firmly to be true, in the present state of our culture. One is constantly finding hints of serious trouble underneath the surface of a well compensated, productive, creative, and well-adjusted man or woman. What we lack is a magic mirror which would make it possible for that individual to look ten or twenty years into the future, to see the price that he will pay for this same nagging problem, which he is able to lock up in a water-tight compartment today.

Let me give you another example of such a problem. One of the most brilliant and gifted human beings I know is at present working through the storms of a profound and bitter depression, with flaring anxieties complicated for the time with a savage drive to smother it all with alcohol. How did this start? It started after the birth of a second child with the sudden eruption of panicky states on leaving her own home. She would start out to drive to the market, and in five minutes she would be seized with a panic so great that she would have to turn around and dash for home. This was a woman with a well-earned international reputation, who had covered the face of the world in her independent travels, happily married to a man she loved,

and with three fine children. Behind this was the story of a tragic childhood, yet she could remember only two experiences of panic. On both occasions she had gotten lost "accidentally on purpose," as the saying goes. Each time she had been holding her little brother by the hand, a little brother who for many reasons had been a major traumatic experience in her early life. She had gone to the store on an errand. Instead of turning back towards home she wandered almost in a daze, holding the little boy by the hand, walking into the nearby woods, losing herself, and then coming to in a state of terror and guilt. Thus in childhood her solution to a destructive home situation had been to run away. In adolescence this actually became the basis for a career in which her gifts and her beauty were fully rewarded, yet left her empty-hearted and lonely until marriage. Then came marriage and children, which brought certain problems in her relationship to her husband and sons. Suddenly the family constellation took on a fantastic resemblance to the family constellation of her early years. At once she was trapped: and about her relationship to her husband and sons feelings came to life which were identical with those which had overwhelmed her in her relationship to her brother and her father. It was in this period that explosive jets of panic began to occur every time she left home; because going to the market was like the childhood episode of running away from home. This started a downhill course into an illness which had gone on for nearly twelve years by the time she came to me. It threatened to destroy her life, her children's health, and that of her husband. How could this gifted, vibrant, successful, beautiful woman have been brought to accept help in time to avoid the disaster that was threatening to overwhelm them all when she came for treatment? If the physician had built a relationship of deep mutual confidence and trust with the patient, such that the patient could tell the story as it really happened! If that physician had discussed the whole story with a psychiatrist and had then laid out a campaign, knowing that it might take some years, knowing that his goal would be gradually to bring this patient to treatment before serious trouble; then even if it had taken four or five years to reach the goal, several years might still have been saved. That is the kind of long-run planning which has to be envisaged in any preventive use of our psychotherapeutic techniques as they evolve in the future. This in turn will require a profound alteration in the climate of medical practice

and indeed in the climate of our entire culture.

The amount of patience and time which this takes, and the quality of the relationship which has to be engendered between the referring physician and the patient give rise to another set of problems which are not easy to deal with.

For one thing it creates a deep loyalty between the patient and the physician which tends to be exclusive, and which can make difficulties in the future treatment of that patient by the psychiatrist. Consequently one wise and experienced physician makes it a rule always to have his assistant take over the physical care of his patient while the patient is in psychotherapy. He remains in the background, to be called on in case of emergency. He does this so as not to let the patient play him off against the psychiatrist during difficult phases of treatment. Where a physician fails to take such precautions, in spite of good intentions his mere presence in the patient's life may render psychotherapy ineffectual. One patient of mine used to stop in to see his physician before each psychotherapeutic session, spilling to his lifelong medical friend and advisor everything which should have been saved for his treatment. The result was that his psychotherapeutic interviews were like eating yesterday's cold potatoes.

We have spent a great deal of time on the difficult problems of early referral. We come next to another important question which has arisen only since psychiatry has begun to be used preventively. This is the danger of psychotic explosions. The whole future of preventive psychiatry depends in part upon how wisely this is handled. We have learned that any neurosis can mask a psychotic potential. Similarly any organic disease can have the same masking effect. Patients may explode out of this latent phase into a psychotic state from sleep, from a dream, from an organic ailment, from a broken leg, out of some apparently superficial neurotic disturbance, from a superficial psychiatric interview or as a reaction to a battery of psychological tests or a battery of organic laboratory procedures. All such manipulations, whether psychological or physiological, can be loaded with symbolic significance to a patient; and this symbolic content, both conscious and unconscious, can be so highly charged that it can touch off a major psychotic explosion. Nor are we prophets enough to be able to predict when this will happen. It is obvious common sense to realize that if the process of examination, of history-taking, of giving

tests, can sometimes explode a psychosis, then there is no perfect way of avoiding such explosions; since we cannot know ahead of time how potentially sick a patient may be until we have examined him. Let me repeat this, since I cannot over-emphasize its importance. The referring doctor must realize that a certain small proportion of patients whom he refers for psychiatric examination and therapy will explode into something serious, almost as soon as they are seen. This has happened to every psychiatrist I know, despite every effort at tact. Indeed tact itself can touch off an explosion. This is another reason why the family physician should talk to the psychiatrist and go over the situation ahead of time to see if the psychiatrist can prognosticate this danger in absentia, even before he has seen the patient. If the danger seems to be at all imminent, then the danger should be discussed with some responsible member of the patient's family, exactly as one discusses surgical risks openly with some responsible representative of a family. Furthermore, if the danger of a psychotic break seems really imminent, then even before an examination is made the costs and methods and alternative places of hospitalization should be discussed with the family. Only rarely do such precautions have to be used: but when they do become necessary the value of having been forehanded about it is incalculable. The family is spared a shocking surprise. The patient's life may be saved. And paradoxical though it may seem a family's mythological fears are lessened when the real dangers, even though remote, are discussed frankly and simply and honestly in terms of realistic precautions. Hence my emphasis is on openness and frankness, insisting that family and patient face all risks with open eyes. This is the best way of lessening the obstacles to treatment which arise out of more fantastic feelings of fear and guilt.

I want to discuss one final problem. Here we are up against another interesting and quite human paradox. Those internists, surgeons, and general practitioners who are most interested in psychiatry, who read about it, who like to discuss the psychiatric implications of their patients with their psychiatric colleagues, are sometimes the very ones who unwittingly do a lot more damage. They do this damage in one of several ways. Sometimes they hold on to their patients too long in the effort to treat them themselves. Sometimes they try to short-cut the whole process of treatment by confronting their patients with blunt

interpretations of the meanings of their symptoms, without considering the explosive after-effects of such precipitate insight. Here again if they will keep in mind certain simple common-sense rules they can avoid difficulty. Long ago the late Dr. William Alanson White, then the Director of St. Elizabeth's Hospital, said, "Never tell a patient that two and two is four. If he thinks it is three or five, he has to think this: and if you try to tell him the obvious, you will either waste your breath or you will precipitate him into a serious emotional explosion." The psychotherapeutic job is patiently to find out why that patient has to believe that two and two make three or five; and once you and the patient have discovered why he has had to believe such a thing you will find that he has discovered for himself that it makes four, and you never need to tell him. In practice what does this mean? It means that the more obvious the untruth, the less value is there to correcting it: the more obvious the meaning of a symptom, the more wary should one be about interpreting it. It means that whenever a patient cannot see the obvious he must *need* his blindness. More than that, it means that the truths about themselves which patients discover as the fruit of painful weeks and months of treatment, may have been quite obvious to all of his friends and relatives and physicians for many years. Indeed these well-meaning individuals may say, "I could have told you that before you ever went to treatment. You did not have to go to anybody to find that out." This is an understandable comment but it misses the whole point of psychotherapy. It is not the truths we discover that make us well: it is the removal of the blinders which obscured the truth. In the meantime, flexible, sensible, conservative use of all practical common-sense methods is the best test that a practitioner can use of the seriousness of any underlying psychiatric disorder. If a patient can use common-sense advice effectively, no more is needed: and our patient cannot have been very ill. When it rolls off the proverbial duck's back, then that duck is ill and needs technical help just as early as it can be brought to bear.